STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

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MEMORANDUM

DATE: February 13, 2004

TO: Long Term Care Facilities

FROM: MDCIS/Clinical Advisory Panel
Quality Improvement Nurse Consultants

SUBJECT: Process Guideline for Pain Management

Best clinical practice is only worthwhile to the extent that we use it to guide care for our residents.

Collaboratively, our current focus areas include improving the management of pain and end-of-life care within long-term care facilities in Michigan. The purpose of the following instructions is to clarify how to apply the Documentation Checklist: Process Guideline for Pain Management. Attached is a copy of the Process Guideline. It is also available on the Quality Improvement Nurse Consultant website: www.michigan.gov/qinc. This optional "best practice" tool for the management of pain was presented to you at the Spring 2002 Joint Provider/Surveyor Training on March 26, 2002. The effective date for usage of the tool was May 1, 2002.

Both facilities and surveyors will have the opportunity to use the Documentation Checklist when resident pain management is of concern. Facilities will be accorded the opportunity to demonstrate that they have followed the steps in this guideline, as evidence to support an appropriate care process related to pain management.

A workgroup including doctors and nurses with experience in geriatrics, nursing home care, and hospice discussed in depth the topic of pain management in the long-term care population. They used available references about geriatric pain management to help them prepare the process guidelines. The documentation checklist contains a series of steps related to managing pain management issues in nursing home residents.

Best clinical practice information helps each facility provide the best possible care throughout the year. Along with information in the federal OBRA regulations, our surveyors will use these process guidelines to review how your facility is managing pain concerns.

PROCESS GUIDELINE FOR PAIN MANAGEMENT

Revised February 2004

CARE STEP PROCESS	EXPECTATIONS	RATIONALE
Assessment And Problem Recognition		
1. Did the facility document that an assessment for pain was begun within 24 hours of admission or recognition of a condition change?	Staff will need to ask residents periodically if they are having pain, at least when they take vital signs. This means asking them such things as "Does it hurt anywhere?" or "Do you have aching or soreness?" For individuals who cannot respond, it means touching, moving, or pressing potentially painful areas (based on an individual's underlying conditions) and observing response. You may need to inquire about or observe for pain more often in someone with conditions such as osteoporosis, hip facture, or vertebral compression fracture that are commonly associated with pain.	The periodic assessment of pain is "key" to identifying and reporting the new onset of pain and/or pain exacerbation as early as possible. Nursing assistants and other direct care-giving staff can identify pain and discomfort in residents during the provision of care. The earlier that pain is identified and reported, the sooner it can be managed. An interdisciplinary approach to pain management should be adopted.
2. Did the facility recognize any triggers for Pain on the Minimum Data Set (MDS)?	When possible indicators of pain have been checked on the MDS, you will need to show that you followed up and considered the possibility of pain. For a list of possible indicators, refer to Table 5, p. 10 of the AMDA 2003 Pain Management Guideline. A resident may also experience episode(s) of acute pain.	The MDS may help with pain assessment. However, the MDS alone does not provide enough details to adequately characterize pain, identify its causes, or select appropriate interventions.
3. Did the facility consider the significance of risk factors that could reflect pain or the risk for having pain?	If a new admission is already taking analgesics, a pain evaluation needs to be initiated regardless of the presence of symptoms. Note any treatments that the patient currently is receiving for pain, including complementary (nonpharmacologic) treatments. There should be evidence of an initial review of the effectiveness of currently used treatments, including medications.	A new admission currently taking analgesics continues to require periodic pain assessment (regardless of symptomatology). This patient may experience a reduction or exacerbation of their pain over time. The effectiveness of pain treatment, including nonpharmacological approaches must be assessed in order to determine whether the treatment plan

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		needs to be modified. In general, particular attention should be paid to someone with a condition that increases the risk of having pain.
4. Did the facility identify and document characteristics (onset, location, intensity, etc.) of the pain?	The expectation is that you will describe and otherwise characterize (for example, frequency and location of the pain and words that describe it, factors that make the pain better or worse, and so on) a person's pain within a week of the initial identification or determination of the presence of pain, and at least periodically thereafter for chronic pain. You are expected to select and use a standardized scale to quantify the intensity of the individual's pain at its best and worst.	Obtaining and documenting as much information as possible related to the patient's experience of pain can help the physician determine appropriate interventions, including medication dosages. For example pain described as "burning" or "shooting" may represent neuropathic pain, which may respond to anticonvulsants, antidepressants, or topical agents such as lidocaine patches. Reliable standard scales have been identified to document and compare pain across time. It is not enough to say that someone "complains of pain," without providing pertinent details.
5. In someone who could not verbalize pain symptoms, did the facility attempt to use alternate means to identify possible pain?	In cognitively impaired individuals, you are expected to use alternative means to inquire or investigate for possible pain; for example, observe the individual for nonspecific signs and symptoms (such as frowning, grimacing, fearful facial expressions, grinding of teeth, striking out, or increasing or recurring agitation), especially during tasks such as dressing changes or turning and positioning, that may suggest the presence of pain. For a list of nonspecific signs and symptoms that might suggest pain, we refer you to Table 4, p. 9 of the AMDA Pain Management CPG.	Pain in the cognitively impaired may be under-treated in cognitively impaired patients. Contrary to a commonly held belief, these patients often can report feelings pain. If they are unable to communicate, looking for nonverbal indicators is a way to assess pain in this population. However, these nonspecific symptoms can also reflect other important conditions such as delirium or fluid and electrolyte imbalance.
6. Did the facility notify a physician or physician extender of the presence of	If current medications and complementary therapies are not relieving pain in a newly admitted resident or in someone	The physician/physician extender needs to be notified of residents with pain

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symptoms that may represent pain?	newly identified as having pain, we expect a physician to review the situation and prescribe or modify an interim regimen within 24 hours of identifying the presence of unrelieved pain, or try to maximize comfort while any additional relevant evaluation (for example looking for causes) proceeds.	management concerns as soon as possible in order to intervene on the residents' behalf. Physician orders can be obtained via telephone within a 24-hour period. Health care practitioners are specifically trained in how to identify causes of symptoms.
Diagnosis/Cause Identification		
7. Did the facility try to identify or clarify specific causes of pain?	We expect you to determine whether causes of pain have been identified or whether an investigation for causes is warranted. We expect you to use your summary of the characteristics and causes of an individual's pain as a basis for identifying causes and creating a related care plan.	Many conditions or diagnoses seen in the long-term care setting can cause acute or chronic pain. Pain management is more successful when the underlying cause of pain is identified and treated.
8. Did the physician or physician extender participate in identifying specific causes of pain, to the extent that a likely medical cause or no cause was identified?	We expect you to show that a physician or another health care practitioner took some relevant medical history and evaluated a resident's pain at some point, especially if the pain is severe, progressive, or not responding to treatment as anticipated.	Most pain management, including the use of analgesics, represents symptomatic relief; these measures only sometimes address the underlying causes of pain. Often the likely cause of pain can be identified from a thorough description of symptoms and physical findings. However, a definitive diagnosis is not always possible.
9. If the resident was not evaluated for causes of pain, does the facility explain why there was not an evaluation, or why an evaluation would not have changed the management?	We recognize that it is not always possible to find or correct an underlying cause of pain. If you determine that to be the case, we expect you to explain why the underlying cause or causes of the pain could not be or should not have been determined or why it was decided that doing so would not affect the treatment or outcome. It isn't enough just to not do or say anything about the situation.	A definitive diagnosis for the cause of pain is often, but not always, possible. Several causes may coexist or a new cause may be equally or more relevant than preexisting conditions.
Treatment/ Problem Management		
10. Is there evidence that interventions to	We expect you to show that you tried to create a relatively	All patients with pain should be cared

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manage pain were initiated at the time of recognition?	comfortable and supportive environment for someone with pain. We expect you to consider at least some of the recognized options for creating such an environment, or indicate why none of those options were relevant or could be provided to that individual (see AMDA 2003 Pain Management CPG, Complementary Therapies in Table 18, p. 30). We don't expect you to offer or use all possible options, but rather to offer those that are relevant to that specific individual.	for in an environment that is as comforting and supportive as possible. Comfort measures such as reassuring words and touch, comforting music, a topical analgesic or a relatively low-risk oral analgesic such as acetaminophen may reduce the need for high doses of pain-relieving medication.
11. Did the facility identify a goal for pain management in someone with pain?	You will need to establish the goals (for example, relief of pain, reduction of pain to a tolerable level, reduce need for breakthrough pain medication, etc.) for an individual's pain treatment, and to be able to explain how you decided on those goals as being reasonable for that individual. We recognize that total pain relief is not always possible.	Setting pain relief goals helps to establish the objectives of pain relief treatment. An interdisciplinary approach that includes input from the resident (if able), and family offers a realistic outlook to guide resident, family, and staff expectations.
12. Does the care plan contain cause-specific or symptomatic interventions, where appropriate, targeted to an individual's conditions, risks, ability to cooperate, etc?	We expect you to be able to explain the basis for a resident's pain management, relative to the findings in the assessment and cause identification phases. We expect you to show how you have taken into account major factors that are relevant to selecting treatments, such as an individual's underlying diagnoses or conditions causing or contributing to chronic pain and his/her preferences or wishes as expressed in an advance directive. We expect you to show that the physician and interdisciplinary team have communicated and reviewed the causes, characteristics, and options related to managing a resident's pain, including nonpharmacologic measures.	After reviewing the characteristics and causes of the resident's pain, an interdisciplinary care plan can be developed that is tailored toward the residents' needs and preferences. Nonpharmacologic or complementary treatments may enhance the effects of medication, allowing smaller doses to be given and thus preventing or reducing medication side effects.

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13. Did the physician or physician extender help identify or authorize symptomatic or cause-specific interventions, as indicated?	We expect you to be able to show that you have followed basic principles of using analgesic medications in the frail elderly and chronically ill (see AMDA 2003 Pain Management Guideline p. 17-27), including the recognition that the elderly may often experience adverse reactions to medications. If not, then we expect you to explain why you chose a substantially different approach. For example, since opiates are not generally recommended as the first-line treatment for chronic musculoskeletal or osteoarthritic pain, we would expect you to be able to explain why they were used initially in someone with such pain without considering other categories of lower risk analgesics first. Or, we would expect you to be able to explain why a long-acting narcotic patch was used in a situation where narcotics were indicated without initially trying a shorter or intermediate-acting form. If the resident is receiving pain medication such as propoxphene, meperidine, pentazocine, or butorphanol, that is generally not recommended in the elderly, we expect you to change the medication or to document why alternatives that are generally considered more appropriate for this population were not chosen or were not considered feasible.	A health care practitioner must authorize relevant interventions. All analgesics have benefits and risks that vary according to the resident's age, diagnosis and conditions, use of other medications, and previous experience with drug or class of drug. In general, older people may be more likely to experience adverse reactions to medications. Medications in many other categories may interact with analgesics and result in adverse drug reactions.
14. Did the facility consistently implement a care plan that included appropriate symptomatic and cause-specific interventions?	We expect you to show us, where relevant, how you have tried to individualize the administration of medications to meet a patient's needs; for example, by recognizing and giving pain medication before certain events or activities known to regularly exacerbate the patient's pain such a dressing changes or turning and positioning. If a resident only has PRN (as needed) analgesics ordered for frequent or continuous pain, and is routinely asking for PRN medications, we expect you to either switch to a standing order for pain medication or to be able to explain why a PRN	When interventions are ordered they should be carried out consistently. Circumstances will help to identify whether a regular or as needed (PRN) medication dosage is indicated. For example, for intermittent or less-severe pain, or when the resident prefers this approach, it may be appropriate to start with PRN dosages and switch to a regular dose if the resident uses the

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	pain regime was maintained.	analgesic more than occasionally. A standing order may also be preferable for residents who are unlikely to be able to request PRN doses.
15. Did the facility document a reason for not implementing or continuing potentially appropriate interventions?	If a resident or substitute decision-maker refuses offered pain relief measure, we expect you to document that, and to show that you have considered basic potentially correctable reasons for such refusal such as unpleasant medication side effects.	Not all interventions are relevant. When a potentially relevant intervention is not used and pain is not controlled there should be a reason. There may be many reasons that residents and/or their families refuse potentially beneficial medications and or approaches to pain management. It is important to discuss with family/residents when this occurs. Sometimes another alternative may be accepted. Persistent refusal should be documented as record of the facilities' efforts on behalf of the resident.
Monitoring		
16. If pain did not respond adequately to selected interventions, did the facility consider alternatives?	For individuals with pain, we expect you to show how you decided whether the current pain management plan was satisfactory. If the resident's pain was not improving to a tolerable level of discomfort, we expect you to show that you have reconsidered current interventions and either modified them or can explain why continuing the current regimen, or not trying alternatives, is considered to be appropriate despite incomplete relief.	Decisions about the continuation of a specific treatment plan (i.e. pharmacologic therapy and complementary therapy) should be based on a review of how well it has achieved the stated care goals. When efforts at pain relief are not successful, alternatives should be considered. Some alternatives may not be relevant, or may present too great of a risk, to a given individual.
17. Did the facility periodically reassess the status of the resident's pain?	We expect you to evaluate the effectiveness of interventions and the status of a person's pain over time, using consistent approaches and tools as in the initial assessment. For	Since pain is often chronic, ongoing evaluation is needed to ensure that it is controlled to the extent possible. Since

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	individuals with chronic pain, we expect you to periodically review whether and to what degree pain is affecting important aspects of quality of life such as ability to perform ADLs and receive ADL assistance, sleep pattern, participation in usual activities, and mood, cognition, and behavior.	many residents in long-term care facilities have predisposing conditions, it is necessary to assess for new onset of pain. Some of those who previously had pain may no longer have it, and can have their analgesics tapered or stopped.
18. Did the facility monitor periodically for significant effects, side effects, and complications of pain medications?	We expect you to show us that you have adjusted the dosages of analgesics to try to meet goals for pain management that were established as part of the care plan, limited by side effects or potential toxicity. For individuals who are receiving long-term analgesics, but do not have pain symptoms, we expect you to at least consider why these medications need to be continued or why it may not be feasible to at least try to taper them, especially if pain symptoms have been stable for more than three months or there is evidence of side effects.	Pain medications are associated with complications, which can be significant. Often, the only way to identify complications that mimic other causes is to be aware of their potential occurrence and be suspicious that a symptom may reflect a complication.
19. Did the facility address significant adverse drug reactions related to pain medications or document why it was not feasible or relevant to do so?	We expect you to monitor for, and to manage significant complications of analgesics, and to adjust medications to balance their therapeutic effects with their undesirable side effects such as lethargy, confusion, anorexia, or increased falls. For instance, if a resident receives narcotics for more than several days consecutively, we expect you to try to prevent severe constipation. If a non-terminally ill individual is having a new or evolving symptoms that could represent adverse side effects, we expect you to either adjust the medication dosages or to document why such an adjustment was not indicated; for example, where significant side effects were considered less important than the primary goal of pain relief.	When medication-related problems occur, they must be addressed. If there is a reason to continue a medication that may be causing a complication, the resident must still be monitored for the potential worsening of the complication.

Table 3

Nonspecific Signs and Symptoms That Suggest the Presence of Pain

- Frowning, grimacing, fearful facial expressions, grinding teeth
- Bracing, rubbing
- Fidgeting, increasing or recurring restlessness
- Striking out, increasing or recurring agitation
- Eating or sleeping poorly
- Sighing, groaning, crying, breathing heavily
- Decreasing activity levels
- Resisting certain movements during care
- Change in gait or behavior
- Loss of function

Table 4

Possible Indicators of Chronic Pain in MDS-Version 2.0

- Sleep cycle (E1)
- Sad, apathetic, anxious appearance (E1)
- Change in mood (E3)
- Resisting care (E4)
- Change in behavior (E5)
- Loss of sense of initiative or involvement (F1)
- Functional limitation in range of motion (G4)
- Change in ADL function (G9)
- Any disease associated with chronic pain (e.g., diabetes, arteriosclerotic heart disease, peripheral vascular disease, arthritis, hip fracture, osteoporosis, pathological bone fracture, stroke, multiple sclerosis, depression) (11)
- Pain (J2)
- Pain site (J3)
- Mouth pain (K1)
- Weight loss (K3)
- Oral status (L1)
- Skin lesions (M1)
- Other skin problems (M4)
- Foot problems (M6)
- Range of motion restorative care (P3)

Table 18

Complementary Therapies

- **Complimentary (Nonpharmacologic) Therapies for Which Evidence of Effectiveness Exists**
    - Education
    - Cognitive/behavioral therapy
    - Exercise

Other Complementary Therapies

Although no scientific evidence supports the effectiveness of these therapies in elderly Patients in the long-term care setting, they may be beneficial to some individuals.

Physical:

- Physical and occupational therapy
- Positioning (e.g., braces, splints, wedges)
- Cutaneous stimulation (e.g., superficial heat or cold, massage therapy, pressure, vibration)
- Neurostimulation (e.g. acupuncture, transcutaneous electrical nerve stimulation)
- Chiropractic

Nonphysical:

- Psychological counseling
- Spiritual counseling
- Peer support groups
- Alternative medicine (herbal therapy, naturopathic and homeopathic remedies)
- Aromatherapy
- Music, art, drama therapy
- Biofeedback
- Meditation, other relaxation techniques
- Hypnosis

AMDA Clinical Practice Guidelines, 1999